STANDARD FORM 93
REV. OCTOBER 1974
PRESCRIBED BY GSA/ICMR
FIRMR (41 CFR) 2001-45.505

APPROVED
OFFICE OF MANAGEMENT AND BUDGET No. 29- R0191

REPORT OF MEDICAL HISTORY

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME - FIRST NAME - MIDDLE NAME		2. SOCIAL SECURITY OR IDENTIFICATION NO.
3. HOME ADDRESS *(No. street or RFD, city or town, State, and ZIP CODE)*		4. POSITION *(title, grade, component)*
5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION	7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS *(Include ZIP Code)*

8. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint exists)*

9. HAVE YOU EVER *(Please check each item)*

YES	NO	*(Check each item)*
☐	☐	Lived with anyone who had tuberculosis
☐	☐	Coughed up blood
☐	☐	Bled excessively after injury or tooth extraction
☐	☐	Attempted suicide
☐	☐	Been a sleepwalker

10. DO YOU *(Please check each item)*

YES	NO	
☐	☐	Wear glasses or contact lenses
☐	☐	Have vision in both eyes
☐	☐	Wear a hearing aid
☐	☐	Stutter or stammer habitually
☐	☐	Wear a brace or back support

11. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	*(Check each item)*	YES	NO	DON'T KNOW	*(Check each item)*	YES	NO	DON'T KNOW	*(Check each item)*
☐	☐	☐	Scarlet fever, ersipelas	☐	☐	☐	Cramps in your legs	☐	☐	☐	"Trick" or locked knee
☐	☐	☐	Rheumatic fever	☐	☐	☐	Frequent indigestion	☐	☐	☐	Foot trouble
☐	☐	☐	Swollen or painful joints	☐	☐	☐	Stomach, liver, or intestinal trouble	☐	☐	☐	Neuritis
☐	☐	☐	Frequent or severe headache	☐	☐	☐	Gall bladder trouble or gallstones	☐	☐	☐	Paralysis *(include infantile)*
☐	☐	☐	Dizziness or fainting spells	☐	☐	☐	Jaundice or hepatitis	☐	☐	☐	Epilepsy or fits
☐	☐	☐	Eye trouble	☐	☐	☐	Adverse reaction to serum, drug, or medicine	☐	☐	☐	Car, train, sea or air sickness
☐	☐	☐	Ear, nose, or throat trouble	☐	☐	☐		☐	☐	☐	Frequent trouble sleeping
☐	☐	☐	Hearing loss	☐	☐	☐	Broken bones	☐	☐	☐	Depression or excessive worry
☐	☐	☐	Chronic or frequent colds	☐	☐	☐	Tumor, growth, cyst, cancer	☐	☐	☐	Loss of memory or amnesia
☐	☐	☐	Severe tooth or gum trouble	☐	☐	☐	Rupture/hernia	☐	☐	☐	Nervous trouble of any sort
☐	☐	☐	Sinusitis	☐	☐	☐	Piles or rectal disease	☐	☐	☐	Periods of unconsciousness
☐	☐	☐	Hay Fever	☐	☐	☐	Frequent or painful urination	☐	☐	☐	
☐	☐	☐	Head Injury	☐	☐	☐	Bed wetting since age 12	☐	☐	☐	
☐	☐	☐	Skin diseases	☐	☐	☐	Kidney stone or blood in urine	☐	☐	☐	
☐	☐	☐	Thyroid trouble	☐	☐	☐	Sugar or albumin in urine	☐	☐	☐	
☐	☐	☐	Tuberculosis	☐	☐	☐	VD - Syphilis, gonorrhea, etc.	☐	☐	☐	
☐	☐	☐	Asthma	☐	☐	☐	Recent gain or loss of weight	☐	☐	☐	
☐	☐	☐	Shortness of breath	☐	☐	☐	Arthritis, Rheumatism, or Bursitis	☐	☐	☐	
☐	☐	☐	Pain or pressure in chest	☐	☐	☐	Bone, joint or other deformity	☐	☐	☐	
☐	☐	☐	Chronic cough	☐	☐	☐	Lameness	☐	☐	☐	
☐	☐	☐	Palpitation or pounding heart	☐	☐	☐	Loss of finger or toe	**12. FEMALES ONLY: HAVE YOU EVER**			
☐	☐	☐	Heart trouble	☐	☐	☐	Painful or "trick" shoulder or elbow	☐	☐	☐	Been treated for a female disorder
☐	☐	☐	High or low blood pressure	☐	☐	☐	Recurrent back pain	☐	☐	☐	Had a change in menstrual pattern
☐	☐	☐		☐	☐	☐		☐	☐	☐	
☐	☐	☐		☐	☐	☐		☐	☐	☐	

13. WHAT IS YOUR USUAL OCCUPATION?

14. ARE YOU *(Check one)*

☐ Right handed ☐ Left handed

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YES	NO	CHECK EACH ITEM YES OR NO, EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT	
☐	☐	**15. Have you been refused employment or been unable to hold a job or stay in school because of:** **A. Sensitivity to chemicals, dust, sunlight, etc.**	
☐	☐	**B. Inability to perform certain motions.**	
☐	☐	**C. Inability to assume certain positions.**	
☐	☐	**D. Other medical reasons** *(If yes, give reasons.)*	
☐	☐	**16. Have you ever been treated for a mental condition?** *(If yes, state reason and give details.)*	
☐	☐	**17. Have you ever been denied life insurance?** *(If yes, state reason and give details.)*	
☐	☐	**18. Have you had, or have you been advised to have, any operations?** *(If yes, describe and give age at which occurred.)*	
☐	☐	**19. Have you ever been a patient in any type of hospitals?** *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*	
☐	☐	**20. Have you ever had any illness or injury other than those already noted?** *(If yes, specify when, where, and give details.)*	
☐	☐	**21. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses?** *(If yes, give complete address of doctor, hospital, clinic, and details.)*	
☐	☐	**22. Have you ever been rejected for military service because of physical, mental, or other reasons?** *(If yes, give date and reason for rejection.)*	
☐	☐	**23. Have you ever been discharged from military service because of physical, mental, or other reasons?** *(If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.)*	
☐	☐	**24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability?** *(If yes, specify what kind, granted by whom, and what amount, when, why.)*	

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."

25. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in items 9 through 24. Physician may develop by interview any additional medical history he/she deems important, and record any significant findings here.)*

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS

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